Restorative Behavioral Health LLC

PATIENT CONTACT FORM

RBI Identifier: _____
SSN: _____

Patient Name: _____ M/F (circle one) DOB: _____ Age: ____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Place of Employment: _____ Department/Phone: _____

Insurance: _____ ID #: _____ Group #: _____

Primary Member/Insured: _____

Parent or Guardian of Minor/Emergency Contact:
Name: _____

Relation to Patient: _____

Home Phone: _____ Cell Phone: _____

Do we have permission to leave detailed medical information and/or test results on your Home or Cell phone? Y/N

Do we have permission to share detailed medical information and/or test results with your Parent or Guardian or Emergency Contact? Y/N

Treatment Preferences:
Preferred Hospital/Clinic: _____
Primary Care Physician: _____ Phone: _____
Preferred Pharmacy (location/cross streets): _____ Phone: _____
Allergies: _____

Restorative Behavioral Health LLC

CONSENT FOR TREATMENT

I, _____, (circle one: Patient/Parent/Legal Guardian/Emergency Contact), hereby consent to obtain and receive treatment and services from Restorative Behavioral Health, LLC, and any of its Affiliates. I understand that the programs offered by RBH are covered under a WRAP model of services, and include: (1) basic life skills and training; (2) psychological rehabilitation; (3) RSP skills program; (4) case management; (5) crisis intervention; (6) neurofeedback and biofeedback; (7) IOP program; and (8) therapeutic counseling (as deemed appropriate for treatment).

I understand that the goal of the program is to encourage personal development and offer individual service plans to empower personal growth, self-esteem, maintain healthy relationships, therapeutic counseling, and goal setting and accomplishment.

I further understand that RBH may suggest certain treatment courses or plans that best suit my needs and/or diagnoses. I agree to communicate with and provide RBH with truthful and accurate information concerning my health, diagnoses, medications, or other treatment information, to ensure that I receive the best and most narrowly-tailored care possible. I agree to indemnify and hold harmless RBH for any issues that may arise as a result of incorrect, incomplete, or omitted information I give or fail to give as part of my care.

I have been fully advised of RBH's processes and treatment services, and I agree to participate in comply with RBH's program rules and regulations. I have the capacity to consent to these services for my own behalf, or on behalf of the patient, minor, or ward for which these services are offered. I am entering into this consent for services on my own volition, and understand that absent a court or law enforcement order, or some other authority, I may terminate my services at any time with notice to RBH.

Patient:
Sign: _____
Date: _____

Parent or Legal Guardian or Emergency Contact:
Sign: _____
Date: _____
Relation to Patient: _____

CONSENT TO TRANSPORT

I, _____, (circle one: Patient/Parent/Legal Guardian/Emergency Contact), hereby authorize Restorative Behavioral Health, LLC, and any of its Affiliates, to provide transportation as needed to or from school, special events, activities, medical appointments, or for any other reason associated with my care/treatment. I understand that there are inherent risks associated with said transportation and travel, including traffic delays, unforeseeable accidents, or other mishaps associated with normal transport. I acknowledge these risks and agree that I will defend and hold harmless RBH and any of its Affiliates from any acts which are not within their control, and which are due to the negligence, recklessness, or purposeful acts of any other third party, treatment or medical facility, or other professional or entity.

I agree to adhere to and comply with all safety protocols and rules and regulations as required by RBH or its transporting Affiliates. I understand that failure to comply with these protocols may result in my suspension or termination from eligibility for transportation services.

For Parents and Legal Guardians:
It is my responsibility to notify my child's school that RBH may transport my child from school to/from RBH's facilities for treatment. This authorization grants RBH permission to transport my child to/from school to attend any necessary treatment services, or to attend parent-teacher school meetings or conferences. I further grant permission for RBH's staff or treatment counselors to attend meeting or classes or other sessions for myself or my child for observation purposes. I understand it is my responsibility to alert RBH of any changes in school, classes, programs, or issues affecting the child's schooling and treatment.

Patient:
Sign: _____
Date: _____

Parent or Legal Guardian or Emergency Contact:
Sign: _____
Date: _____
Relation to Patient: _____
Child's School: _____ Contact/Phone: _____
School Address: _____

Restorative Behavioral Health LLC

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

As part of its commitment to providing you with the best and most cost-effective and efficient treatment, RBH and its Affiliates, from time to time, may wish to communicate with you or any entity, treating physician, medical professional, or other third party, via electronic means, including electronic mail, patient/record portal, facsimile, text message, e-signature software, or others. You have the right to select how you receive your health information.

Examples of information which may be sent electronically to you or third parties:

- Appointment reminders, cancellations, rescheduling
- Telehealth appointments
- Contact information changes
- Office closures
- Prescription information
- Test results, lab results, follow-up appointments

There are certain categories of information which cannot be shared with you or third parties in electronic form (HIV/AIDS status, communicable disease status, etc.) except with your express permission or by law. RBH will not disseminate information which is not permitted to be disclosed by local, state, or federal law or regulation.

RBH strives to keep all patient information confidential, and will take appropriate steps to safeguard your information in its internal files and when transmitting such information by electronic means. This may include implementing or using encryption software, password protected files, and/or secure servers or portals. Whenever possible, RBH, in its discretion, will use such devices to ensure that your data is protected. RBH will use its best practices and professional standards in determining which information is appropriate for electronic dissemination.

No company, including RBH, can insure against outside attacks or third party criminal or unauthorized breaches of such information. RBH has a duty to inform you of any unauthorized disclosure of your information, and will do so in writing in accordance with local, state, and federal laws and regulations. You agree to hold harmless and indemnify RBH for any data breaches or criminal or unauthorized breaches or disclosure of your information which are not the responsibility of RBH, or which was not caused by its recklessness or purposeful actions.

By this consent, you agree that RBH may transmit or share your information with you as follows (select all that apply):

____ Electronic mail	____ Text message (standard data rates apply as charged by your carrier)
____ By voicemail	____ Facsimile
____ Online portal (username and password required)	____ Paper/in person/mail only (copy rates and mailing fees may apply as allowed by law)

You may revoke this authorization at any time with written notice to RBH.

Patient:
Sign: _____
Date: _____

Parent or Legal Guardian or Emergency Contact:
Sign: _____
Date: _____
Relation to Patient: _____

Disclaimer: RBH is not responsible for any unauthorized access or dissemination of your information which arise out of any server attacks, unauthorized disclosure, or data breach by any Internet Service Provider (ISP), such as Yahoo, Google, Gmail, Hotmail, Microsoft, or any other electronic platform. You are encouraged to protect your PHI and any communications or messages from your medical providers by removing such content from your inbox or portals once accessed, and by using standard anti-virus software or other protective measures. It is not recommended to access or maintain electronic communications of PHI and other confidential information on shared or public devices. It is the patient's or parent/guardian's responsibility to maintain the confidentiality of all electronic information once it is sent through the proper channels and with the proper protective protocols from RBH.

Restorative Behavioral Health LLC

CONSENT TO BILL INSURANCE
PATIENT FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, counseling, therapy, or any services offered by RBH. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive, and I agree to make payment in full if any of these services are not covered by insurance.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card.

If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary carrier for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer

will deny payment for that service. We suggest to all patients that they contact their insurance to confirm that the anticipated services are covered.

By signing this form, I agree that I will be financially responsible for any uncovered services or costs, and that I will immediately pay for my portion of said uncovered services or costs at the time of treatment. I understand that if refuse to sign this consent or revoke it at any time after signing, RBH may refuse to provide services to me only in accordance with the law (except in the case of an emergency).

I further understand that RBH has no obligation to bill or invoice my insurance company or me for any covered or uncovered services, and that it shall be within RBH's sole discretion to provide or refuse to provide services unless and until payment is secured. If RBH does provide said services, and it is determined at the time of service or at a later time that the services were not covered by insurance, I consent to having RBH bill or invoice me for any outstanding balances. I agree that if any outstanding balances become uncollectible from me or my representative, RBH has the right to use all reasonable legal means to secure payment, including engaging legal collection practices under the Fair Debt Collection Practices act and other federal, state, and local laws.

Patient:
Sign: _____
Date: _____

Parent or Legal Guardian or Emergency Contact:
Sign: _____
Date: _____
Relation to Patient: _____

Restorative Behavioral Health LLC

CREDIT CARD AUTHORIZATION FORM

Please complete all fields.

This authorization will remain in effect until cancelled.

You may cancel this authorization at any time by contacting us.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): _____

Card Number: _____ CVV: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I authorize RBH and any of its affiliates to charge my card for agreed upon purchases and services. I understand that my information will be saved for future transactions on my account, and that RBH may bill for outstanding balances either at the time of services or upon any determination that services rendered are not covered by insurance.

Patient:

Sign: _____

Date: _____

Parent or Legal Guardian or Emergency Contact:

Sign: _____

Date: _____

Relation to Patient: _____

Restorative Behavioral Health LLC

CANCELLATION AND NO-SHOW POLICY

At RBH, our goal is to provide quality urological care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of urological care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment, procedure appointment or scheduled surgery appointment.

Please be courteous and call RBH promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of services. Available appointments are in high demand and your early cancellation will allow us to schedule someone else for services.

No Show/Cancellations

Patients who fail to show for their scheduled appointment or who do not notify the office within 24 hours of their scheduled appointment time shall be subject to a "No Show/Cancellation" fee of $50.00. In the event of an actual emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.

Late Arrival

We understand that delays can happen. However, we must try to maintain an efficient schedule for all patients. If you are more than 15 minutes late, we may ask you to reschedule your appointment to another date and time.

How to Cancel or Reschedule Your Appointment

To cancel or reschedule appointments, call RBH at 702-806-6195. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

I have read and understood the policy, and consent to be bound by it.
Patient:
Sign: _____
Date: _____

Parent or Legal Guardian or Emergency Contact:
Sign: _____
Date: _____
Relation to Patient: _____

Restorative Behavioral Health LLC

NOTICE OF PRIVACY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition, and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Rights describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties with whom we have contracted to perform various business activities necessary to our care (e.g., billing, recordkeeping, or transcription services). Said businesses are required to maintain appropriate safeguards and protocols for the protection of PHI. PHI may only be used internally for teaching or training purposes with your authorization.

When Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Disclosure Where Prior Authorization Not Required. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization include disclosures:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

We also are not required to obtain prior disclosure authorization for the following categories of cases:

- Abuse and Neglect
- Judicial and Administrative Proceedings
- Emergencies
- Law Enforcement
- Protection of National Security
- Public Safety (Duty to Warn)

Verbal Permission. We may use or disclose your information with your verbal permission to individuals or entities that are directly involved in your treatment.

With Authorization. If there are any other uses or disclosures not specifically permitted, we will not make such disclosures except with your written authorization, which you may revoke in writing at any time.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer at restorativebh@outlook.com.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.

- **Right to Select Physician of Choice**. You have the right to select a qualified provider of your choice under the provision of the Division of Healthcare and Financing Policy Medicaid Chapter 400. All services offered at RBH are voluntary. Your signature on this form indicates that you understand your right.

ELECTRNIC SUBMISSION AND HANDLING OF PHI

From time to time as required, we may disclose or share your PHI by electronic means, including but not limited to, electronic mail, facsimile, or online portal. Any information shared in such manner will be encrypted or otherwise protected from unauthorized access or disclosure. Should you consent to the electronic transmission of your PHI (which is optional), we may require you to create a username, password, or other authentication measures to ensure that only you or other authorized users can access the electronic PHI.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, at (702) 853-6727 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

HIPAA PROGRAM MANAGEMENT

For questions, concerns, or complaints, please contact:

Booker Collins, Coordinator
702-853-6727

Global Compliance Hotline
(888) 691-0772
Umcsn.alertline.com

YOUR PRIVACY AND PROTECTION ARE IMPORTANT TO US!

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ DOB: _____

I,_____, hereby authorize Restorative Behavioral Health (RBH) and any of its Affiliates, to disclose to and/or obtain Personal Health Information (PHI), from _____for the purpose of providing treatment, assessment, diagnoses, and plan of care.

Description of Information to be Disclosed

Please select the categories you consent to being shared with third parties:

____ Assessment	____ Testing Information
____ Diagnosis	____ Educational Information
____ Psychological Evaluation	____ Presence/Participation in Treatment
____ Care Plan/Treatment	____ Progress Information/Treatment Update
____ Disability	____ Substance Abuse/Addiction History
____ Appointments/reminders	____ Family History Diagnoses
____ HIV/AIDS Status	____Other
____ All Categories	

*Please note that RBH will disclose to any medical or government authority information which is required to be disclosed by law.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to RBH. I further understand that RBH is entitled tor rely on this authorization prior to receiving written notice of revocation, and any action or disclosure taken prior to RBH receiving notice of the revocation shall be effective until notice is received.

Expiration

This authorization shall remain in effect for the duration of the patient's participation in RBH's programs, unless revoked at an earlier date. Otherwise, this authorization expires on the following specified date: _____.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that

we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Re-Disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____.

Acknowledgement/Consent: I acknowledge that I have received and had an opportunity to review this form. I understand that if I have questions regarding the Notice or my privacy or disclosure rights, I can contact the Privacy Officer at (702) 853-6727. I also specifically acknowledge that I have been made aware of my right to select the physician of my choice for treatment.

Patient:
Sign: _____
Date: _____

Parent or Legal Guardian or Emergency Contact:
Sign: _____
Date: _____
Relation to Patient: _____

Staff Witness:
Sign: _____
Date: _____

Restorative Behavioral Health LLC

MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐Hepatitis	☐Chickenpox
	☐Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Drug/Medication	Strength/Dosage	Frequency Taken

Allergies to medications	
Drug/Medication	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No

	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Grandmother** *Maternal*		
Mother					
Sibling					
			Grandfather *Maternal*		
Children			**Grandmother** *Paternal*		
			Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No

Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	